WASHINGTON STATE
EARLY CHILDHOOD EDUCATION AND ASSISTANCE PROGRAM

Child Information

1. Child's name: Last: _____   First: _____   Middle: _____

2. Child's birth date *(mm/dd/yyyy)*: ____/____/_____   3. Sex: ☐ F ☐ M

4. Living Address: _____   City: _____   State: ____   Zip: _____

5. Mailing Address: _____   City: _____   State: ____   Zip: _____

6. County: _____   7. School District *(if known)*:_____

8. Daytime phone: (_____)_____-_____   Evening Phone: (_____)_____-_____

9. Is child of Spanish/Hispanic/Latino ethnicity *(optional)*: ☐ Yes ☐ No   *This question is about ethnicity, not race. Please answer question #10 by marking one or more boxes to indicate what you consider child's race to be.*

10. Race *(optional)*:   ☐ White   ☐ American Indian or Alaska Native   ☐ Black or African American
    ☐ Asian   ☐ Native Hawaiian/Pacific Islander   ☐ Other: _____

11. Languages spoken in home: Primary: _____   Secondary: _____

12. Child has Individual Education Plan (IEP): ☐   *If checked, school district*: _____

13. Family receives DSHS Child Care Subsidies for this child: ☐ Yes ☐ No

14. Child is homeless according to the McKinney-Vento Act: ☐ Yes ☐ No   *The McKinney-Vento Homeless Assistance Act defines "homeless children and youths" as "individuals who lack a fixed, regular, and adequate nighttime residence…;" and "includes children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or campgrounds; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement…"*

15. Child resides with:
    ☐ Single parent/caretaker with legal responsibility for child *(in joint custody cases, use parent that receives child support)*
    ☐ Two parents/caretakers with legal responsibilities for child
    Parent(s)/caretaker(s) include: biological or adoptive parents, legal stepparents, legal guardians, foster parents, caretaker blood relatives with legal responsibility for child.

Legal Parent/Caretaker Information

16. Name (Last, First, MI):	_____	_____
17. Gender:	☐F ☐M	☐F ☐M
18. Relationship to child:	☐ Parent (biological/adoptive) ☐ Parent (legal stepparent) ☐ Grandparent ☐ Foster parent *(If yes, skip to question #26)* ☐ Other caretaker relative:_____ ☐ Other legal guardian	☐ Parent (biological/adoptive) ☐ Parent (legal stepparent) ☐ Grandparent ☐ Foster parent *(If yes, skip to question #26)* ☐ Other caretaker relative:_____ ☐ Other legal guardian
19. Age:	☐ Under 18 ☐ 36-45 ☐ 18-24 ☐ 46-55 ☐ 25-35 ☐ Over 55	☐ Under 18 ☐ 36-45 ☐ 18-24 ☐ 46-55 ☐ 25-35 ☐ Over 55
20. Education level:	☐ 6th grade or less ☐ Some college ☐ 7th–9th grade ☐ 2-year degree ☐ 10th–12th grade ☐ 4-year degree ☐ High School Diploma ☐ Other ☐ GED _____	☐ 6th grade or less ☐ Some college ☐ 7th–9th grade ☐ 2-year degree ☐ 10th–12th grade ☐ 4-year degree ☐ High School Diploma ☐ Other ☐ GED _____
21. Check any education or training currently involved in *(check all that apply):*	☐ ESL ☐ High School Completion ☐ GED ☐ Even Start ☐ Voc/tech program ☐ Other _____ ☐ College ☐ None	☐ ESL ☐ High School Completion ☐ GED ☐ Even Start ☐ Voc/tech program ☐ Other _____ ☐ College ☐ None
22. Employment status:	☐ Full-time ☐ Looking for work ☐ Part-time ☐ Not looking for work	☐ Full-time ☐ Looking for work ☐ Part-time ☐ Not looking for work
23. Migrant/seasonal farm worker:	☐ Yes ☐ No	☐ Yes ☐ No
24. Parent/Caretaker is enrolled in medical/dental plan *(check all that apply)*:	☐ Medicaid ☐ Medicare ☐ Washington Basic Health Plan ☐ Washington Basic Health Plan Plus ☐ Private/Employer Medical Insurance ☐ Private/Employer Dental Insurance ☐ No Medical Insurance ☐ No Dental Insurance ☐ Other	☐ Medicaid ☐ Medicare ☐ Washington Basic Health Plan ☐ Washington Basic Health Plan Plus ☐ Private/Employer Medical Insurance ☐ Private/Employer Dental Insurance ☐ No Medical Insurance ☐ No Dental Insurance ☐ Other
25. Parent/Caretaker has primary health care provider/medical home:	☐ Yes ☐ No	☐ Yes ☐ No

Household Information

26. Total household income: Previous 12 month's gross income: $ _____ and current gross monthly income: $ _____

    Which income reflects family's current circumstances? ☐ Previous 12 month's gross income ☐ Current gross monthly income

    Household income includes all persons living in the same household who are (a) supported by the income of the parent(s) or guardian(s) of the child enrolling in ECEAP, and (b) related to the parents or guardians by blood, marriage, adoption, or legal obligation to provide support. (WAC 365-170-030 (9.) In cases of homelessness as defined by the McKinney Vento Homeless Assistance Act (see question #14), families are automatically eligible for ECEAP, but still need to provide household income (when/if available). Income for foster children is always assumed as zero and a family of one.

27. Number of persons in household supported by this income: _____

    a) Check if family is over income: ☐ Federal Poverty Level (FPL) _____%
    b) If child is from over income family, check why child qualifies for ECEAP:
       ☐ Child is at risk due to environmental factors.   ☐ Child is at risk due to developmental factors.

28. Income source *(check all that apply):*
    ☐ Wages/Salary   ☐ Child support   ☐ Pension, retirement, and/or Social Security
    ☐ Supplemental Security (SSI)   ☐ Unemployment benefits   ☐ Alimony/spousal support
    ☐ TANF   ☐ Other: _____

29. Family accesses the following social services *(check all that apply):*
    ☐ Food stamps   ☐ WIC   ☐ Energy assistance   ☐ Homeless services
    ☐ Food banks   ☐ Housing subsidies ☐ Other local programs *(please specify)*: _____

Child Medical/Dental/Health Information

30. Child is enrolled in the following medical insurance and/or child health programs *(check all that apply):*
    ☐ Medicaid   ☐ Washington Basic Health Plan   ☐ Private medical insurance
    ☐ Children's Health Insurance Program (CHIP)   ☐ Washington Basic Health Plan Plus   ☐ No medical insurance   ☐ Other

31. Child is enrolled in the following dental insurance and/or dental health programs *(check all that apply):*
    ☐ Medicaid, Washington Basic Health Plan Plus, or Children's Health Insurance Program (CHIP) *These health programs include dental coverage.*
    ☐ Private dental insurance   ☐ No dental insurance   ☐ Other

32. Child has primary health care provider/medical home: ☐ Yes ☐ No

33. Date of last medical exam *(prior to first service date)*: _____/_____/_____

    If date of last medical exam was completed over one year ago or left blank, provide date medical exam completed while in ECEAP *(must be completed within 90 days of the first service date)*: _____/_____/_____

34. Date of last dental exam *(prior to first service date)*: _____/_____/_____

    If date of last dental exam was completed over six months ago or left blank, provide date dental exam completed while in ECEAP *(must be completed within 90 days of the first service date)*: _____/_____/_____

35. Child is fully immunized with age appropriate vaccines (per DOH Immunization Schedule): ☐ Yes ☐ No *RCW 28A.210.160 requires a completed Certificate of Immunization Status on file at the school, preschool, or child care facility child attends (except in cases of homelessness).*

    a) If child is not fully immunized at time of enrollment, an immunization schedule is in progress: ☐ Yes ☐ No
    b) If child is not immunized, a DOH required Statement of Exemption to Immunization Law is signed and on file: ☐ Yes ☐ No
    c) Date child became fully immunized while in ECEAP: _____/_____/_____

I certify that the foregoing is true and correct. ECEAP is funded with state funds; therefore, some or all of the information provided must be reported to other state agencies. In addition, the information may be provided to non-governmental research firms under contract with the Department of Community, Trade, and Economic Development. The information will be kept confidential to the extent required or authorized by state and federal law.
There must be a signature on all three lines.

36. _____   _____
    Signature of parent or guardian   *Date*

37. _____   _____
    Signature of interviewer   *Date*

38. _____   _____
    Signature of person who verified income/established eligibility   *Date*

Enrollment Information:
39. Enrollment date: _____/_____/_____ *(Date when enrollment process is confirmed and slot is reserved.)*
40. Did child receive ECEAP services in the previous year: ☐ Yes ☐ No
41. Has child received ECEAP services from another contractor this program year: ☐ Yes ☐ No If yes, what city? _____
42. Child will be transported by ECEAP: ☐ One way   ☐ Both ways   ☐ Not transported by ECEAP

43. Site code: _____   First service date: _____/_____/_____   Exit date: _____/_____/_____
Transfers/Returns: *(To be used when child transfers from another ECEAP site, or exits the program and returns during the same program year.)*
44. ☐Transfer/☐Return   Site code: _____   Service date: _____/_____/_____   Exit date: _____/_____/_____
45. ☐Transfer/☐Return   Site code: _____   Service date: _____/_____/_____   Exit date: _____/_____/_____
Comments to CSU: _____
Form type: ☐ New enrollment ☐ Update medical-dental ☐ Update transfer or return ☐ Notify that child exited